

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04585

Reg. Dist. No. 332

4586

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>400 Camden Ave.</u>				d. STREET ADDRESS <u>400 Camden Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Wilbert</u> Middle <u>Lee</u> Last <u>Beacham</u>				4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 8, 1924</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>CECIL R. BEACHAM</u>				14. MOTHER'S MAIDEN NAME <u>LANNIE GUTHRELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give nature of service) <u>yes</u> <u>W.M.H.</u>				16. SOCIAL SECURITY NO. <u>324-28-3590</u>		17. INFORMANT <u>Thelma Beacham</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> <u>921.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Strangulated inguinal hernia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 days</u> <u>2 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Aspiration of vomitus</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4-2</u> p. m. <u>19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-3-57</u>			
22a. BURIAL, CREMATION, REMOVAL Specify <u>BURIAL</u>		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEARWOOD CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ROANOKE RAPIDS, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + JOHNSON Co. Salisbury, Md.</u> <u>Norman T. Baker</u>				24a. REC'D BY REGISTRAR <u>4-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

MEDICAL CERTIFICATION

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF WITNESS		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF JURY		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF JUDGE		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF CLERK		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF SHERIFF		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF CORONER		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF JURY		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF JUDGE		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF CLERK		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF SHERIFF		DATE		TIME		LOCATION		HOURS		MINUTES	
SIGNATURE OF CORONER		DATE		TIME		LOCATION		HOURS		MINUTES	

BUREAU V. S.

APR 5 1957

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04586

332

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>App: 20yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>115 Priscilla St</b>				STREET ADDRESS (If rural give location) <b>115 Priscilla St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>ROSA</b>		(Middle) <b>LEE</b>		(Last) <b>BENSON</b>		(Month) <b>APRIL</b> (Day) <b>15th</b> (Year) <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 16, 1884</b>	9. AGE last birthday <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>J. Walter Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Cox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. J. Lee Benson - cr - Mr. J. Sheet Benson (Son) Ocean City Rd. Salisbury, Maryland</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE			
331X IMMEDIATE CAUSE (A) <b>CEREBRO VASCULAR ACCIDENT</b>				YEARS			
ANTECEDENT CAUSE(S) DUE TO (B) <b>HYPERTENSION</b>				YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>GENERALISED ATHEROSCLEROSIS.</b>				YEARS			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>PREVIOUS STROKES.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4/22</b> , 19 <b>55</b> , to <b>4/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/15</b> , 19 <b>57</b> , and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Dr. O. J. Burton</b>				ADDRESS (Street, city, town, state) <b>M. D. Maruland Ave. Salisbury, Maryland</b> DATE SIGNED <b>4/15/57</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr. 17, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR DATE <b>APR 17 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY * SALISBURY, MARYLAND</b>			

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Mr. J. Lee Benson (son) 6125 N.E.  
California, Portland

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APR 17 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4588

## CERTIFICATE OF DEATH

Reg. Dist. No.

04587  
332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>300 N. Division St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>MARCELLUS</u> Middle <u>WILLIAM</u> Last <u>B. OUNDS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Feb. 27, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>President</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George Bouds</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bouds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-10-8142</u>	
(If yes, give war or dates of service) <u>W.W.I</u>		17. INFORMANT <u>W.H. Smith Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Rt. upper + lower lobes</u> DUE TO (b) <u>Chronic Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Rheumatoid Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericarditis, Mononucleosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October, 1956</u> , to <u>April 21, 1957</u> , that I last saw the deceased alive on <u>April 21, 1957</u> , and that death occurred at <u>12:02 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u>		ADDRESS (Street, city or town, state) <u>224 N. Division St. Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr.</u>		DATE SIGNED <u>4/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mardela, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 4-22-57</u>	
ADDRESS <u>Norman S. Baker</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Halloray</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4589

CERTIFICATE OF DEATH

Reg. Dist. No.

04588

337

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>			c. LENGTH OF STAY IN 1b <b>4 yrs. 6 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold (Anne Arundel) Maryland</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl Lee Boyce</b>				4. DATE OF DEATH Month Day Year <b>April 13 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1878</b>	
9. AGE (In years lost birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Boyce Deceased</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Barrow Deceased</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>unk</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CVD</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized</b> DUE TO (c) <b>Decubitus ulcers</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Oct. 14, 19 52</b> to <b>April 13, 19 57</b> , that I last saw the deceased alive on <b>April 13, 19 57</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve</b>				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>			
DATE SIGNED <b>April 14, 1957</b>							
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Stine</b>				ADDRESS <b>Charlottesville, Virginia</b>		24a. REC'D BY REGISTRAR <b>APR 17 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

CERTIFICATE OF DEATH

Part One

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1910		New York City		123 Main St		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Death		Place of Death		Physician		Hospital		Burial Place	
Teacher		High School		Married		Apr 15, 1957		Baltimore		Dr. Smith		St. Mary's		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family		Signature of Minister		Signature of Undertaker		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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APR 17 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04589

Reg. Dist. No.

332

4590

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>837 E. William St</b>				d. STREET ADDRESS <b>837 E. William St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>EDWARD</b> Middle <b>THOMAS</b> Last <b>BRADFORD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2nd</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1871</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Month <b>11</b> Day <b>14</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Onley, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Bradford</b>				14. MOTHER'S MAIDEN NAME <b>Mary Metcalfe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Emma Bradford (Wife)</b> <b>Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>APR 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary T. Hallways</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04590337

4591

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>In Village</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida</u> <u>GERTRUDE</u> <u>Brittingham</u>		4. DATE OF DEATH Month Day Year <u>4</u> <u>10</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10th, 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John William White</u>		14. MOTHER'S MAIDEN NAME <u>Laura Freeny</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Lester W. Brittingham (Son) Pittsville, Maryland</u> <u>Mr. Walter G. Brittingham (Son) Pittsville, Maryland</u>	
17. INFORMANT <u>Mr. Lester W. Brittingham (Son) Pittsville, Maryland</u> <u>Mr. Walter G. Brittingham (Son) Pittsville, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 hours</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D. <u>Salisbury, Md</u>		DATE SIGNED <u>4-10-57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr.</u>		Medical Center, Salisbury, Maryland <u>4/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Apr. 12, 1957</u>	<u>Pittsville Cemetery</u>	<u>Pittsville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. RECEIVED BY REGISTRAR <u>APR 12 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

STANDARD STATE

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BUREAU K. S.

APR 12 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

04591

4648

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>				c. LENGTH OF STAY IN 1b <u>10 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Drowned Wicomico River</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert</u> <u>Carlton</u> <u>Brown</u>				4. DATE OF DEATH Month Day Year <u>4-16</u> <u>19</u> <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Trainmaster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George R. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Helena Munson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. II 705-09-4275</u>		17. INFORMANT Address <u>Ethel Thelma Brown, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 850, X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fishing boat capsized.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fishing boat capsized.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>4-16-57</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wicomico River</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Butler Co. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Butler, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>4-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollomay</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 30 1957

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4592 **CERTIFICATE OF DEATH**

04592

337

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fruitland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS <u>Main St</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>GEORGE WASHINGTON CAUSEY</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>1st</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 8, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A. Causey</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Maude E. Causey (Wife) Main St. Fruitland, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
609x IMMEDIATE CAUSE (A) <u>Peritonitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10-12 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>urinary extravasation</u>				<u>45 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ruptured urethra</u>				<u>45 days</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Benign prostatic hypertrophy</u>				<u>2-3 years</u>			
19a. DATE OF OPERATION <u>2/17/32 1/3/13-57</u>		19b. MAJOR FINDINGS OF OPERATION <u>urinary extravasation</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office/bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 10, 1957</u> , to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Raymond E. Yow</u>				ADDRESS (Street, city, town, state) <u>M.D. 707 Camden Ave. Salisbury, Maryland</u>			
DATE SIGNED <u>Apr. 2 1957</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 3, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 4 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</u>			

# CERTIFICATE OF DEATH

Block Date, 1957

1. PLACE OF DEATH: \_\_\_\_\_

2. NAME OF DECEASED: \_\_\_\_\_

3. SEX: \_\_\_\_\_

4. AGE: \_\_\_\_\_

5. DATE OF BIRTH: \_\_\_\_\_

6. PLACE OF BIRTH: \_\_\_\_\_

7. OCCUPATION: \_\_\_\_\_

8. CAUSE OF DEATH: \_\_\_\_\_

9. MANNER OF DEATH: \_\_\_\_\_

10. DATE OF DEATH: \_\_\_\_\_

11. TIME OF DEATH: \_\_\_\_\_

12. SIGNATURE OF DECEASED: \_\_\_\_\_

13. SIGNATURE OF WITNESS: \_\_\_\_\_

14. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

15. SIGNATURE OF CORONER: \_\_\_\_\_

16. SIGNATURE OF JURY: \_\_\_\_\_

17. SIGNATURE OF JUDGE: \_\_\_\_\_

18. SIGNATURE OF CLERK: \_\_\_\_\_

19. SIGNATURE OF NOTARY: \_\_\_\_\_

20. SIGNATURE OF DECEASED: \_\_\_\_\_

21. SIGNATURE OF WITNESS: \_\_\_\_\_

22. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

23. SIGNATURE OF CORONER: \_\_\_\_\_

24. SIGNATURE OF JURY: \_\_\_\_\_

25. SIGNATURE OF JUDGE: \_\_\_\_\_

26. SIGNATURE OF CLERK: \_\_\_\_\_

27. SIGNATURE OF NOTARY: \_\_\_\_\_

28. SIGNATURE OF DECEASED: \_\_\_\_\_

29. SIGNATURE OF WITNESS: \_\_\_\_\_

30. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

31. SIGNATURE OF CORONER: \_\_\_\_\_

32. SIGNATURE OF JURY: \_\_\_\_\_

33. SIGNATURE OF JUDGE: \_\_\_\_\_

34. SIGNATURE OF CLERK: \_\_\_\_\_

35. SIGNATURE OF NOTARY: \_\_\_\_\_

36. SIGNATURE OF DECEASED: \_\_\_\_\_

37. SIGNATURE OF WITNESS: \_\_\_\_\_

38. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

39. SIGNATURE OF CORONER: \_\_\_\_\_

40. SIGNATURE OF JURY: \_\_\_\_\_

41. SIGNATURE OF JUDGE: \_\_\_\_\_

42. SIGNATURE OF CLERK: \_\_\_\_\_

43. SIGNATURE OF NOTARY: \_\_\_\_\_

BUREAU V. S.

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, address, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4593 CERTIFICATE OF DEATH

Reg. Dist. No.

04593

332

1. PLACE OF DEATH a. COUNTY <b>Wiconico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 9 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Lena</b> Last <b>Collins</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Ryan</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Timmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>578x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gastro-intestinal hemorrhage</b> DUE TO (c) <b>260x Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>5</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1955</b> , to <b>April 1, 1957</b> , that I last saw the deceased alive on <b>April 1, 1957</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. V. Maldve</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		DATE SIGNED <b>4/2/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>April 13, 1957</b>		22b. DATE THEREOF <b>April 13, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>I O O F</b>		22d. LOCATION (City, town, or county) (State) <b>Bishopville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter W. Haley</b>		24. REGISTRAR'S SIGNATURE <b>Mary H. Hallways</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery		Signature of Interment		Signature of Burial		Signature of Cremation		Signature of Other	
John Doe		Male		45		1912		Boston, Mass.		Boston, Mass.		Heart Disease		April 1, 1957		10:00 AM		Home		Natural		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe			

BUREAU V. 3

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04594

4649

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. Seaford Del R7D#3</u>				d. STREET ADDRESS <u>P.O. Seaford Del R7D3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE PRIESTLEY COLLISON</u>				4. DATE OF DEATH Month Day Year <u>4-5-1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1890</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bridgeton Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Priestley</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Bostick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT Address <u>Walter J. Collison, Salisbury</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tonsillitis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7 days</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/4/57</u> , 19 <u>57</u> , to <u>4/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/5/57</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.S. Kuhlman</u>				ADDRESS (Street, city or town, state) <u>Salisbury Del</u>		DATE SIGNED <u>4/6/57</u>	
PHYSICIAN'S NAME (Type) <u>H.S. Kuhlman</u>				M.D. <u>S. Kuyperman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Marshall-Shayton</u>				ADDRESS <u>Imperial</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloman</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED  <i>John Doe</i></p>		<p>2. SEX  <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE  <i>45</i></p>		<p>4. DATE OF BIRTH  <i>Jan 15 1912</i></p>	
<p>5. PLACE OF BIRTH  <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION  <i>Teacher</i></p>	
<p>7. CAUSE OF DEATH  <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal</p>	
<p>9. DATE OF DEATH  <i>Apr 8 1957</i></p>		<p>10. TIME OF DEATH  <i>10:30 AM</i></p>	
<p>11. PLACE OF DEATH  <i>Home</i></p>		<p>12. SIGNATURE OF PHYSICIAN  <i>John Doe</i></p>	
<p>13. SIGNATURE OF DECEASED  <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS  <i>John Doe</i></p>	

BUREAU V. 1

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4594

CERTIFICATE OF DEATH

Reg. Dist. No.

04595  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Md.</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Queenstown 17x12.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>James Randolph Comegys</b> First Middle Last				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 12, 1889</b>		
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Comegys</b>				14. MOTHER'S MAIDEN NAME <b>Susan Hassett</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-32-2205</b>		17. INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <b>1</b> p. m. Month, Day, Year <b>19 57</b>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 4, 19 57</b> to <b>April 6, 19 57</b> , that I last saw the deceased alive on <b>April 5, 19 57</b> , and that death occurred at <b>1:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>4/6/57</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. <b>Deer's Head State Hospital</b> PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b> <b>Salisbury, Maryland</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>Apr. 8-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Centerville, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Burton, Jr.</b>				ADDRESS <b>P.O. Box, Centerville, Md.</b>		24. REC'D BY REGISTRAR <b>Mary M. Holloray</b>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04598

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Burlington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>CityPark</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverside 67x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CityPark</b>			d. STREET ADDRESS <b>119 Jefferson St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RONALD</b> Middle <b>WAYNE</b> Last <b>CORRY</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1946</b>		9. AGE (In years last birthday) <b>11</b> yrs. <b>0</b> Months <b>29</b> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pennsylvania</b>	
13. FATHER'S NAME <b>Wallace W. Corry</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Alinda James</b>		
16. SOCIAL SECURITY NO. <b>Mr. Wallace W. Corry (Father)</b>			17. INFORMANT <b>119 Jefferson St. Riverside, New Jersey</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>929.8</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child wading and stepped into deep water.</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>4</b> o. m. <b>28</b> p. m. <b>57</b>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Stream in park.</b>			
20f. (City or town) <b>Salisbury</b>		20g. (County) <b>Wicomico</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Hills Cemetery Philadelphia, Pennsylvania</b>	
22d. LOCATION (City, town, or county) <b>Salisbury, Md.</b>		22e. (State) <b>Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 3 1957</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John J. Jones		45		Male		White		March 12, 1957		Boston, Mass.	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
123 Main St., Boston		Carpenter		Heart Disease		Natural		[Signature]		[Signature]	
Physician		Hospital		Burial		Interment		Date of Burial		Place of Burial	
Dr. J. A. Smith		St. Mary's		Catholic		Catholic		March 15, 1957		St. Mary's Cemetery	

RECEIVED  
MAY 3 1957  
BUREAU V. A.

4596

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Chenango</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Smithville Center</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>JOHNSON</b> Last <b>JOHNSON COWLES</b>				4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 18, 1866</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John T. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Lydia White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>G lenn Cowles</b> Address <b>W. Union Ave., Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sensility.</b> (c) <b>Arterio-sclerotic heart disease.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/22</b> , 19 <b>57</b> , to <b>4/29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/29</b> , 19 <b>57</b> , and that death occurred at <b>6:20 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. C. Mitchell</b>				ADDRESS (Street, city or town, state) <b>211 Maryland Ave. Salisbury, Md.</b>			
DATE SIGNED <b>4/29/57</b>							
PHYSICIAN'S NAME (Type) <b>Dr. A. C. Mitchell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5/2/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co.</b>				ADDRESS <b>Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-30-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>							

CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		35		M		W		1922		BALTIMORE		MD		USA		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
MARRIED		1945		BALTIMORE		MD		USA		USA		1957		BALTIMORE		MD	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
MANAGER		1950		BALTIMORE		MD		USA		USA		1957		BALTIMORE		MD	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
HEART DISEASE		1957		BALTIMORE		MD		USA		USA		1957		BALTIMORE		MD	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
NATURAL		1957		BALTIMORE		MD		USA		USA		1957		BALTIMORE		MD	
SIGNATURE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAMES J. JONES		1957		BALTIMORE		MD		USA		USA		1957		BALTIMORE		MD	

BUREAU V. 2

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04598

4597

## CERTIFICATE OF DEATH

Reg. Dist. No.

832

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3601-4</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>107 S. Monroe Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Christina</b> Middle <b>Cross</b> Last <b>Cross</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21, 1874</b> <b>11/21/1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>James Cross</b>			
14. MOTHER'S MAIDEN NAME <b>Annie Mayhen</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myxedema</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 2</b> , 1952, to <b>April 22</b> , 1957, that I last saw the deceased alive on <b>April 22</b> , 1957, and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>4/22/57</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b> <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Md.</b> <b>Dorman T. Baker</b>				24a. REC'D BY REGISTRAR DATE <b>4-24-57</b>		24b. REGISTRAR'S SIGNATURE <b>Maryell Holloway</b>	

11. Johnson & Johnson

4650

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMOS T. DASHIELL</u>				4. DATE OF DEATH Month Day Year <u>April 18 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1871</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>3 25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Levin J. Dashiell</u>				14. MOTHER'S MAIDEN NAME <u>Martha White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Emily Travers Dashiell, Tyaskin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Sept., 1948</u> to <u>18 April, 1957</u> that I last saw the deceased alive on <u>18 April, 1957</u> and that death occurred at <u>3:20 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D. <u>Nanticoke, Md.</u>				DATE SIGNED <u>4/20/57</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u> <u>4/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Private Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Green Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. T. Messick</u> ADDRESS <u>Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4-20

BUREAU V. 1

APR 23 1957

RECEIVED

E. 4651

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home-Hebron Md.</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>A</b> Last <b>Dashiell</b>				4. DATE OF DEATH Month <b>4</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/1899</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>James Dashiell</b>				14. MOTHER'S MAIDEN NAME <b>Margrette Giles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-7964</b>		17. INFORMANT Address <b>Stella Dashiell Hebron Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhages</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>20 days</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1 Apr 1957</b> to <b>21 Apr 1957</b> , that I last saw the deceased alive on <b>21 Apr 1957</b> , and that death occurred at <b>6:45 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6524 main ST Salisbury Md.</b> DATE SIGNED <b>25 Apr 57</b>							
ACTUAL SIGNATURE <b>F. A. Purnell</b>				M.D. <b>Salisbury Md.</b>			
PHYSICIAN'S NAME (Type) <b>F. A. Purnell, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Center Stewart</b>				ADDRESS <b>Salisbury Md.</b>		24a. REC'D BY REGISTRAR <b>APR 29 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollings</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

APR 29 1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04601

332

Reg. Dist. No. ....

4652

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Powellville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Powellville</u>		CITY OR TOWN <u>Powellville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.# 2 (Pittsville Route)</u>		STREET ADDRESS (If rural give location) <u>R.D.# 2</u>					
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Edna</u>		<u>Dennis</u>		<u>April</u>		<u>3rd</u> 19 <u>57</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Oct. 12, 1889</u>	<u>67</u> yrs.	<u>5</u> Months	<u>21</u> Days	<u></u> Hours <u></u> Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>House Work</u>		<u>at Home</u>		<u>Delmar, Maryland</u>		<u>U S A</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Joshua H. Parker</u>				<u>Mary Emily Riley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>				<u>Mr. Robert A. Dehnis, (Husband) R.D.# 2 Pittsville Route - Powellville, Maryland</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<u>4 yrs.</u>			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				<u>6-8 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatoid arthritis</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>1950</u>, 19 <u>4-3</u>, to <u>4-3</u>, 19 <u>57</u>, that I last saw the deceased alive on <u>4-3</u>, 19 <u>57</u>, and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Frank R. Lewis M.D. Willards</u>				<b>DATE SIGNED</b> <u>April 5 / 57</u>			
<b>Dr. Frank R. Lewis.</b>				<b>M.D. Main St. Willards, Maryland</b>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> <b>(State)</b>	
<u>Burial</u>		<u>Apr. 6, 1957</u>		<u>Dennis Family Cemetery</u>		<u>Powellville, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>APR 8 1957</u>		<u>Mary V. Holloway</u>		<u>HOLLOWAY &amp; COMPANY FUNERAL HOME</u>		<u>SALISBURY</u>	
<b>MARYLAND</b>							

BUREAU V. S.

APR 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 0460232									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>607 Smith St</b>					d. STREET ADDRESS <b>607 Smith St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HILDA R DUNN</b>					4. DATE OF DEATH Month <b>April</b> Day <b>10</b> th <b>19</b> Year <b>57</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 8, 1933</b>		9. AGE (in years last birthday) <b>23</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Employee (Stenographer)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Harford County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Milton Watts</b>					14. MOTHER'S MAIDEN NAME <b>Grace Tull</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. John M. Watts (Father) R.D.# 3</b> <b>Salisbury, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound of heart</b> DUE TO 976x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased shot herself in bed at home</b>						
20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> <b>4-9-57</b> <b>19</b> a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury Wicomico Md.</b>		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Apr. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>					24a. REC'D BY REGISTRAR <b>APR 15 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John A. Jones		AGE 45		SEX Male		RACE White		DATE OF DEATH April 15, 1957	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		MOTHER Mrs. J. A. Jones		FATHER Mr. J. A. Jones	
PREVAILING ILLNESS Heart Disease		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		SIGNATURE OF EXAMINER Dr. J. A. Jones		DATE April 15, 1957	

BUREAU V. 5

APR 15 1957

RECEIVED

4599

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE.</u> b. COUNTY <u>SUSSEX.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Del MAR. 46 X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>304 N. Second St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PRESTON O ELLIS</u>				4. DATE OF DEATH Month Day Year <u>April 27 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 15 1885</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RR Co</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RR Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George F. ELLIS</u>				14. MOTHER'S MAIDEN NAME <u>JALLIE OLIPIANT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>EDWARD F. ELLIS, Delmar, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Coronary Artery Disease with Heart Block</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 22, 1957</u> , to <u>April 27, 1957</u> , that I last saw the deceased alive on <u>April 27, 1957</u> , and that death occurred at <u>7:08 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>224 N. Division St. April 28 '57</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>N. B. Gishawon</u>				ADDRESS <u>Laurel Del</u>		24a. REC'D BY REGISTRAR DATE <u>5/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MAY 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04604

4600

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill 23x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>M.</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26-1883</u>	9. AGE (In years last birthday) <u>73 1/4</u>	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John Evans</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Margaret Britton</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-25-3748</u>				17. INFORMANT <u>Mrs Sattie Evans</u> Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-vdisease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-24-</u> , 19 <u>57</u> , to <u>4-25-</u> , 19 <u>57</u> that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>Salisbury, Md.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wheeler H. Fisher Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 25, 1957</u>		<u>Worcester</u>		<u>Snow Hill</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Evans</u> ADDRESS <u>Snow Hill, md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Cause of Death, and other medical details. Includes handwritten entries such as "Robert M. Evans" and "1928-1973".

RECEIVED  
APR 29 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04605

4601

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 5, Maryland</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State</b>		d. STREET ADDRESS <b>927 N. Rose St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Fisher</b> Last <b>Fisher</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1890</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Mary Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial insuffic.</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Cor Pulmonale</b> DUE TO (c) <b>Pulmonary fibrosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 d.</b>  <b>years</b>  <b>"</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>St. post resiction of 4th left rib.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o. 11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Salisbury, Maryland</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Apr. 3, 1957</b> , to <b>Apr. 13, 1957</b> , that I last saw the deceased alive on <b>April 13, 1957</b> , and that death occurred at <b>11:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>Apr. 14, 1957</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b> <b>Deer's Head State Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 17 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mountain Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Harford Co</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road</b>		24a. REC'D BY REGISTRAR <b>APR 15 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1912		Maryland		Farmer		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF REGISTRAR	
April 16, 1957		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. SOCIAL SECURITY NUMBER		22. MEDICAL EXAMINER'S NAME		23. MEDICAL EXAMINER'S ADDRESS		24. MEDICAL EXAMINER'S PHONE	
Anne Arundel		Pikesville		Maryland		21114		123-456789		Dr. J. H. Harris		123 Main St.		123-4567	
25. NAME OF FUNERAL HOME		26. ADDRESS OF FUNERAL HOME		27. PHONE OF FUNERAL HOME		28. NAME OF MINISTER		29. ADDRESS OF MINISTER		30. PHONE OF MINISTER		31. NAME OF CLERGYMAN		32. ADDRESS OF CLERGYMAN	
J. H. Harris		123 Main St.		123-4567		Rev. J. H. Harris		123 Main St.		123-4567		Rev. J. H. Harris		123 Main St.	

BUREAU V. A.

APR 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4692

CERTIFICATE OF DEATH

Reg. Dist. No.

04606  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>57yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pemberton Drive</b>				d. STREET ADDRESS <b>Pemberton Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Bell</b> Last <b>Gray</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 26, 1871</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry Gray</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Watt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>214-32-6913</b>		17. INFORMANT Address <b>Pemberton Drive</b> <b>Mrs. Geo. B. Gray Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>8 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/28</b> , 19 <b>57</b> , to <b>4/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/28</b> , 19 <b>57</b> , and that death occurred at <b>5 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. R. Gramse</b>				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>4/29/57</b>			
PHYSICIAN'S NAME (Type) <b>F. R. Gramse, M.D.</b>				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/30/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parson Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas H. Waller</b>				ADDRESS <b>Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 1 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. H.

MAY 1 1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

4603

04607

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>12</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>		STREET ADDRESS (If rural give location) <u>915 Hanover St.</u>					
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>BLANCH</u>		(Middle) <u>M</u>		(Last) <u>HARRINGTON</u>		(Month) (Day) (Year) <u>APRIL 4th 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 20th, 1880</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Dyson Welch</u>				14. MOTHER'S MAIDEN NAME <u>Mary Yohe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mr. Elton W. Harrington (Son) 915 Hanover St Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
4343 IMMEDIATE CAUSE (A) <u>Pneumonia &amp; Intestinal obstructions</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Enlarged Heart Congestive failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/2</u> , 19 <u>57</u> , to <u>4/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/4</u> , 19 <u>57</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Andrew C. Mitchell</u>				DATE SIGNED <u>Apr. 5/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 6, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Bivalve Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bivalve, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>8 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</u>			

# CERTIFICATE OF DEATH

Form 10-57-10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Contributing cause)

11. Place of death (City, State, Country)

12. Signature of physician (Print name)

13. Signature of physician (Print name)

14. Signature of physician (Print name)

15. Signature of physician (Print name)

16. Signature of physician (Print name)

17. Signature of physician (Print name)

18. Signature of physician (Print name)

19. Signature of physician (Print name)

20. Signature of physician (Print name)

21. Signature of physician (Print name)

22. Signature of physician (Print name)

23. Signature of physician (Print name)

24. Signature of physician (Print name)

25. Signature of physician (Print name)

26. Signature of physician (Print name)

27. Signature of physician (Print name)

28. Signature of physician (Print name)

29. Signature of physician (Print name)

30. Signature of physician (Print name)

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Contributing cause)

11. Place of death (City, State, Country)

12. Signature of physician (Print name)

13. Signature of physician (Print name)

14. Signature of physician (Print name)

15. Signature of physician (Print name)

16. Signature of physician (Print name)

17. Signature of physician (Print name)

18. Signature of physician (Print name)

19. Signature of physician (Print name)

20. Signature of physician (Print name)

21. Signature of physician (Print name)

22. Signature of physician (Print name)

23. Signature of physician (Print name)

24. Signature of physician (Print name)

25. Signature of physician (Print name)

26. Signature of physician (Print name)

27. Signature of physician (Print name)

28. Signature of physician (Print name)

29. Signature of physician (Print name)

30. Signature of physician (Print name)

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Contributing cause)

11. Place of death (City, State, Country)

12. Signature of physician (Print name)

13. Signature of physician (Print name)

14. Signature of physician (Print name)

15. Signature of physician (Print name)

16. Signature of physician (Print name)

17. Signature of physician (Print name)

18. Signature of physician (Print name)

19. Signature of physician (Print name)

20. Signature of physician (Print name)

21. Signature of physician (Print name)

22. Signature of physician (Print name)

23. Signature of physician (Print name)

24. Signature of physician (Print name)

25. Signature of physician (Print name)

26. Signature of physician (Print name)

27. Signature of physician (Print name)

28. Signature of physician (Print name)

29. Signature of physician (Print name)

30. Signature of physician (Print name)

BUREAU V. S.

APR 8 1957

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that a death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be delivered with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04608

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Willards</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>R.D. #</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>MARY</b>		(Middle) <b>CATHERINE</b>		(Last) <b>HEARN</b>		(Month) (Day) (Year) <b>April 20th 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 4, 1918</b>		9. AGE last birthday <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>R.D. # Willards, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel T. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Manie Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Robert T. Hearn (Husband) R.D. # Willards, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <b>Chronic glomerulonephritis</b>						<b>unknown</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4-26</b> , 19 <b>57</b> , to <b>4-29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-29</b> , 19 <b>57</b> , and that death occurred at <b>12:05A</b> , from the causes and on the date stated above.							
SIGNATURE <b>Dr. Wilber R. Ellis, Jr.</b>				ADDRESS (Street, city, town, state) <b>M.D. Medical Center-Salisbury, Maryland</b>			
DATE <b>4/30/57</b>				DATE SIGNED <b>4/30/57</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial-</b>		DATE THEREOF <b>May 2, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Jones Cemetery</b>		LOCATION (City, town, or county) (State) <b>Powellville, Maryland</b>	
24. REC'D BY REGISTRAR DATE <b>MAY 2 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

# CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

John William Williams  
 2. Date of death (Month, day, year)  
 3. Place of death (City, town, village, or other locality)

4. Name of physician (Print or write full name)  
 5. Name of medical examiner (Print or write full name)

6. Name of funeral director (Print or write full name)  
 7. Name of undertaker (Print or write full name)

8. Cause of death (Print or write full name)  
 9. Date of death (Month, day, year)  
 10. Place of death (City, town, village, or other locality)

11. Name of physician (Print or write full name)  
 12. Name of medical examiner (Print or write full name)  
 13. Name of funeral director (Print or write full name)  
 14. Name of undertaker (Print or write full name)

15. Name of physician (Print or write full name)  
 16. Name of medical examiner (Print or write full name)  
 17. Name of funeral director (Print or write full name)  
 18. Name of undertaker (Print or write full name)

19. Name of physician (Print or write full name)  
 20. Name of medical examiner (Print or write full name)  
 21. Name of funeral director (Print or write full name)  
 22. Name of undertaker (Print or write full name)

BUREAU V. S.

MAY 2 1957

RECEIVED

RECEIVED - BALTIMORE, MARYLAND

RECEIVED - BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 F11mG21h 4-29-57 et

CERTIFICATE OF DEATH

04609

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>4605</b> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesleysville 23x22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Chesleysville 23x22</u>	
3. NAME OF DECEASED (Type or print) First <u>Parker</u> Middle <u>Hickman</u> Last <u>Hickman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry Raiser</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Hickman</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-8834</u>	
17. INFORMANT <u>Ralph Cary - Georgetown Seal</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.1</u> <u>Dysplastic Sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 year</u> DUE TO (c) <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-16-57</u> , 19 <u>57</u> , to <u>4-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-21-57</u>	
PHYSICIAN'S NAME (Type) <u>W. S. Marshall Co. Helma Seal</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Georgetown Seal</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall Co. Helma Seal</u>		24a. REC'D BY REGISTRAR <u>APR 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The form is mostly blank with some faint handwriting.

BUREAU V. 3

APR 23 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04610

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.# (Meadow Bridge Rd)</b>				d. STREET ADDRESS <b>R.D.# (Meadow Rd. Fruitland)</b>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>HENRY</b> Last <b>HITCH</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>23rd</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 24, 1869</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b>29</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		11. BIRTHPLACE (State or foreign country) <b>R.D.# (Fruitland) Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel M. Hitch</b>				14. MOTHER'S MAIDEN NAME <b>Hettie Ann Driscoll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. J. Harold Hitch (Son) 164 Sheldon Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <b>XX</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 26, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery - R.D.# Eden - Somerset Co. Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24. REG'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. (last name)		Male		45		Caucasian		1957		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		Teacher		High School		Married		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

PR 29 1957

RECEIVED

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4606

## CERTIFICATE OF DEATH

(Husband of-Late-Charles Edward Holloway)

Reg. Dist. No. 332

04611

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Hebron (Rural)</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Hill Private Sanitarium</b>				STREET ADDRESS <b>R.D.# 1</b>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>CARRIE</b> (Middle) <b>MARIAN</b> (Last) <b>HOLLOWAY</b>				(Month) <b>April</b> (Day) <b>29</b> (Year) <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 7, 1874</b>	9. AGE last birthday <b>83</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Fredrick A. Crockett</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Graham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Claude J. Holloway (Son) Quantico, Md.</b> <b>Mr. C. Edward Holloway (Son) Quantico, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) <b>Cardiovascular renal disease</b>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 55 to 4-29, 19 57, that I last saw the deceased alive on 4-29, 19 57, and that death occurred at 4:15P M, from the causes and on the date stated above.							
SIGNATURE <b>Dr. Philip A. Insley</b>				ADDRESS (Street, city, town, state) <b>M. E. Main St. Salisbury, Maryland</b>			
DATE SIGNED <b>Apr. 30 1957</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 2nd 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery (Old Sec)</b>		LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
24. REC'D BY REGISTRAR <b>MAY 2 1957</b>		REGISTRAR'S SIGNATURE <b>Mary St. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

# CERTIFICATE OF DEATH

(To be filled out by the physician or other qualified person)

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death	
Mary Elizabeth Jones		Female		85		Jan 7, 1894		Jan 11, 1979		Home		Heart Disease		Natural	
Residence		Married		Single		Married		Single		Home		Hospital		Accident	
City		County		State		Country		City		County		State		Country	
Baltimore		Harford		Maryland		U.S.A.		Baltimore		Harford		Maryland		U.S.A.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home		Signature of Family		Signature of Neighbor		Signature of Other	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 5

MAY 2 1957

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NOTED: This certificate is a legal document and must be filled out correctly. It is the responsibility of the physician or other qualified person to provide accurate information. The certificate is used for statistical purposes and to determine the cause of death. It is also used to determine the manner of death. The certificate is a legal document and must be filled out correctly. It is the responsibility of the physician or other qualified person to provide accurate information. The certificate is used for statistical purposes and to determine the cause of death. It is also used to determine the manner of death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

4654

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>40 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>410 Elizabeth Street</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1957</b>							
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Ashland</b> Last <b>Hurley</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 12, 1881</b>	
9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Eden, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Theopolus Hurley</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Willey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>716-03-1679</b>			
17. INFORMANT <b>Helen Hurley, Delmar, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Cardiac Failure</b> 364X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocard Endocarditis</b> DUE TO <b>Myocardial Infarction</b> (c) <b>Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4.3 hr</b> <b>6.3 hr</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March 22, 1957</b> , to <b>April 17, 1957</b> , that I last saw the deceased alive on <b>April 15, 1957</b> , and that death occurred at <b>9 A.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. H. Lynch</b>				ADDRESS (Street, city or town, state) <b>Delmar, Del.</b>			
PHYSICIAN'S NAME (Type) <b>L. H. Lynch</b>				DATE SIGNED <b>April 17, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Gammel Co., Delmar, Del.</b>				24a. REC'D BY REGISTRAR <b>APR 17 1957</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		40 yrs		10-25-1957		110 Elm Street, Baltimore, Md.	
Cause of Death		Occupation		Marital Status		Date of Birth		Place of Birth	
Heart Disease		Teacher		Married		10-25-1917		Baltimore, Md.	
Immediate Cause		Underlying Cause		Manner of Death		Date of Death		Place of Death	
Myocardial Infarction		Coronary Atherosclerosis		Natural		10-25-1957		110 Elm Street, Baltimore, Md.	
Contributing Cause		Hypertension		None		10-25-1957		110 Elm Street, Baltimore, Md.	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.	
J. H. Smith, M.D.		J. H. Smith		110 Elm Street, Baltimore, Md.		123-4567		12345	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's Phone		Registrar's License No.	
A. B. Jones, Registrar		A. B. Jones		110 Elm Street, Baltimore, Md.		123-4567		12345	
Date of Death		Place of Death		Date of Death		Place of Death		Date of Death	
10-25-1957		110 Elm Street, Baltimore, Md.		10-25-1957		110 Elm Street, Baltimore, Md.		10-25-1957	

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APR 23 1957

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 12, 13, 14 Film G214 4-22-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

04613  
332

4607

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke 23x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Kirkwood</u> Middle <u>Kirkwood</u> Last				4. DATE OF DEATH <u>April</u> Month <u>2</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3 1906</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-16-7561</u>				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/28</u> , 19 <u>57</u> , to <u>4/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>224 N. Division St. Salisbury, Md.</u>			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type)				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ginsley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>4-12-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>				24c. REGISTRAR'S SIGNATURE			

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4608 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04614

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>1 507 South Park Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DONALD</b>		First <b>C</b> Middle <b>G</b> Last <b>KNARR</b>		4. DATE OF DEATH <b>APRIL 24 th 19 57</b>		Month <b>APRIL</b> Day <b>24 th</b> Year <b>19 57</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 22, 1921</b>	
9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee of Ice Cream Co. Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Frank L. Knarr</b>		14. MOTHER'S MAIDEN NAME <b>Twila H. Hile</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II</b>		17. INFORMANT <b>Mr. Frank L. Knarr (Father) 2900 Sylvan Ave. Baltimore 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <b>Notural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>April 24 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEONARD J. RUCK, INC. FUNERAL HOME - BALTIMORE, MD.</b>				24a. REC'D BY REGISTRAR <b>APR 25 1957</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Place of Birth		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death	
John J. Brown		Boston, Mass.		October 2, 1901		Male		White		Single		None		Heart Disease	
Residence of Deceased		Place of Death		Date of Death		Time of Death		Place of Death		Cause of Death		Cause of Death		Cause of Death	
123 Main St., Boston, Mass.		Boston, Mass.		October 15, 1957		10:30 A.M.		Hospital		Heart Disease		Heart Disease		Heart Disease	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Deceased		Signature of Deceased		Signature of Deceased		Signature of Deceased	
J. J. Brown		J. J. Brown		J. J. Brown		J. J. Brown		J. J. Brown		J. J. Brown		J. J. Brown		J. J. Brown	



BUREAU V. 5

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04615

4609

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Centreville, 17x22</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T.</u> Last <u>Langford</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U SA</u>	
13. FATHER'S NAME <u>Wm. Langford</u>				14. MOTHER'S MAIDEN NAME <u>? --</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>		17. INFORMANT <u>Deer's Head Records</u> Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease,</u> <u>422.1</u> DUE TO <u>decompensated, with cardiomegaly.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>57</u> , to <u>April 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>57</u> , and that death occurred at <u>4:35 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/8/57</u>							
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		M.D. _____					
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		Deer's Head State Hospital, Salisbury, Md.					
22a. BURIAL, CREMATION, REINSTATE (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Hill Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. of Butler Bros. Centerville, MD.</u>		ADDRESS <u>Centerville, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Rodonay</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		1892		Maryland		Baltimore		Maryland		United States	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
OCCUPATION		PROFESSION		INDUSTRY		TRADE		BUSINESS		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
EDUCATION		SCHOOLING		ATTENDANCE		DEGREE		CITY		STATE		COUNTRY		DATE	
None		None		None		None		None		None		None		None	
RELIGION		CHURCH		MINISTER		PASTOR		CITY		STATE		COUNTRY		DATE	
None		None		None		None		None		None		None		None	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		CITY		STATE		COUNTRY		DATE	
None		None		None		None		None		None		None		None	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE		TIME	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		CITY		STATE		COUNTRY		DATE	
None		None		None		None		None		None		None		None	

BUREAU V. S.

APR 12 1957

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04616

## 4610 CERTIFICATE OF DEATH

Reg. Dist. No. 33 ✓

1. PLACE OF DEATH COUNTY <u>Chesapeake</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Chesapeake</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> STREET ADDRESS (If rural give location) <u>806 Lake St</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Olevia P. Lenkford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> <u>15</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>7-6-83</u>
9. AGE last birthday <u>73</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>4</u> <u>15</u> <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Eden MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Hale</u>		14. MOTHER'S MAIDEN NAME <u>Louise Hayman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Nora Lenkford</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>Indefinite</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>15 Nov</u> , 19 <u>57</u> , to <u>15 Apr</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 Apr</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, or state) <u>Salisbury MD</u> DATE SIGNED <u>17 Apr 57</u> M.D. <u>652 W. Main</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4-15-57</u>	NAME OF CEMETERY OR CREMATORY <u>Park Rd. Cem.</u>	LOCATION (City, town, or county) <u>Salisbury MD</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Post, W. West</u>	ADDRESS _____
DATE <u>APR 29 1957</u>			

SHOOTING

1. Name of person killed: JAMESON, J. MADISON  
2. Date of shooting: APR 29 1957  
3. Place of shooting: [illegible]  
4. Name of shooter: [illegible]  
5. Name of witness: [illegible]  
6. Name of doctor: [illegible]  
7. Name of coroner: [illegible]  
8. Name of police officer: [illegible]  
9. Name of prosecutor: [illegible]  
10. Name of judge: [illegible]  
11. Name of jury: [illegible]  
12. Name of jury foreman: [illegible]  
13. Name of jury clerk: [illegible]  
14. Name of jury bailiff: [illegible]  
15. Name of jury usher: [illegible]  
16. Name of jury stenographer: [illegible]  
17. Name of jury interpreter: [illegible]  
18. Name of jury translator: [illegible]  
19. Name of jury interpreter: [illegible]  
20. Name of jury translator: [illegible]

# 2010 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10

BUREAU V. 1

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4611

CERTIFICATE OF DEATH

04617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>Race Street Extended</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebecca T. Lankford</u>		4. DATE OF DEATH Month Day Year <u>April 26 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1873</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zora M. Lankford</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Wheatley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 12</u> , 19 <u>57</u> to <u>Apr. 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Deer's Head State Hospital</u> <u>4/27/57</u>			
ACTUAL SIGNATURE <u>L. J. Guerman</u>		M.D. <u>Deer's Head State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>V. Guerman, M.D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 29, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Thomas</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>4/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Hall</u>	

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A34

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES ALBERT		MALE		35		JAN 15 1924	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED	
MAY 10 1957		BALTIMORE, MD.		JAMES ALBERT		JAMES ALBERT	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED	
MAY 10 1957		BALTIMORE, MD.		JAMES ALBERT		JAMES ALBERT	

**RECEIVED**  
 MAY 6 1957  
 BUREAU V. E.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04618

4655

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Tyaskin</u>			
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>ELIZABETH</u> Last <u>LARMORE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/1871</u>		9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Tyaskin, Md.</u>	
13. FATHER'S NAME <u>Frank Dickerson</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
14. MOTHER'S MAIDEN NAME <u>Insley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>			
16. SOCIAL SECURITY NO. <u>-----</u>				17. INFORMANT <u>Percy Larmore, Tyaskin, Maryland</u> Address <u>-----</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>54 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>16 May</u> , 19 <u>49</u> , to <u>18 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>18 April</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D. <u>Nanticoke Md.</u>				DATE SIGNED <u>18 April 57</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u> <u>4/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Perschke</u> , <u>Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1910</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1935</i></p>	
<p>9. NAME OF SPOUSE <i>John A. Smith</i></p>		<p>10. DATE OF DEATH <i>Jan 15 1957</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>16. SIGNATURE OF DECEASED <i>John A. Smith</i></p>	

BUREAU V. 1

PR 23 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of the certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4612

## CERTIFICATE OF DEATH

04619

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>35 Days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>16 West-East St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>ANDREW</b> (Middle) <b>JACKSON</b> (Last) <b>LIVELY</b>				(Month) <b>APRIL</b> (Day) <b>10</b> (Year) <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>October 11, 1869</b>	9. AGE last birthday <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Willis Lively</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Hill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMATION & ADDRESS <b>Mrs. Faith Kunde (Daughter) 16 W/East St. Delmar, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
610X IMMEDIATE CAUSE (A) <b>Acute dilatating heart</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10-12 hrs</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Surgery (prostatectomy, transurethral)</b>						<b>14 hrs.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Senility</b>						<b>10 years</b>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic cholecystitis, old peptic ulcer</b>						<b>unknown</b>	
19a. DATE OF OPERATION <b>4-9-57</b>		19b. MAJOR FINDINGS OF OPERATION <b>Benign prostatic hypertrophy</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4-6</b> , 19 <b>57</b> , to <b>4-10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-10-57</b> and that death occurred at <b>2:20A</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Raymond M. You</b>				ADDRESS (Street, city, town, state) <b>Salisbury, Maryland</b>			
Dr. Raymond M. You M.D. Camden Ave.-				DATE SIGNED <b>Apr. /57</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Apr. 13, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>APR 15 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

# CERTIFICATE OF DEATH

Reg. No. 12

1. DECEASED'S NAME (Last, first, middle)

Wisconsin

Maryland

Maryland

Maryland

John Deane

30 years

Salisbury

12 North East St.

East. Gen. Hospital

April 10, 1957

LIANY

JANSON

ANIMUS

28

5

87

October 17, 1958

VIENNA

VIENNA

Male

U.S.A.

John Deane

Salisbury

Salisbury

John Deane

John Deane

John Deane (husband) is buried at  
John Deane, Maryland

is buried at

is buried at

is buried at

is buried at

is buried at

is buried at

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is buried at

BUREAU V.

APR 15 1957

RECEIVED

John Deane, Salisbury, Maryland

John Deane, Salisbury, Maryland

April 15, 1957

Salisbury

HOLBERT & COMPANY - BALTIMORE

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04620

4613

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Selbyville Del.</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville 46x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Selbyville 46x-3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First <u>Lynch</u> Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1957</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>X</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Nadine Hickman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Lynch Selbyville, Del.</u> Address <u>RED# 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/19</u> , 19 <u>57</u> , to <u>4/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>57</u> , and that death occurred at <u>5:05 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. <u>Medical Center Salisbury</u>				<u>4/21/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>I O O F</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u> ADDRESS <u>Selbyville, Del.</u>				24a. REC'D. BY REGISTRAR <u>DATE 4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

2082452XVI

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1912"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
DATE OF DEATH [Faint text, possibly "April 20, 1957"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	

BUREAU V. 3

APR 25 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4614

## CERTIFICATE OF DEATH

04621

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Emerson Mapp</b>				4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 30, 1918</b>		9. AGE (In years lost birthday) yrs. <b>38</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Night Club</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Jennings Mapp</b>			
14. MOTHER'S MAIDEN NAME <b>Priscilla Jacobs</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> 44-46			
16. SOCIAL SECURITY NO. <b>012-14-4782</b>				17. INFORMANT Address <b>Mrs. Novella Mapp, 110 2nd St., Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinosis of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify, that I attended the deceased from <b>15 May, 1957</b> to <b>16 May, 1957</b> that I last saw the deceased alive on <b>16 May, 1957</b> , and that death occurred at <b>9:30 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>652 W. Main St., Salisbury, Md</b> DATE SIGNED <b>18 April 57</b>							
ACTUAL SIGNATURE <b>E. A. Purnell</b>				M.D. <b>652 W. Main St., Salisbury, Md</b>			
PHYSICIAN'S NAME (Type) <b>E. A. Purnell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>APR 22 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollaway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIED		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER	
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64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

BUREAU V. S.

APR 22 1957

RECEIVED

27-3-57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04622

## 4615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>828 E. Church Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>S.</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1919</u>		
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reginald Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Laura Shockley</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WW #11</u>				16. SOCIAL SECURITY NO. <u>216-18-8695</u>		17. INFORMANT <u>Mrs Mae D. Matthews, Salisbury, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombo phlebitis of lower extremities</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Weeks</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unoperated lithotomy - right - 4-4-57</u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 20 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>Marjorie H. Halloway</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4016

CERTIFICATE OF DEATH

Reg. Dist. No.

0462337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>233 E. College Avenue</b>							
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>S.</b> Last <b>McDowell</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/26/1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>19</b> Days <b>57</b> Hours <b>57</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Early</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Towers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes and obesity</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury, Maryland</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Jan. 30</b> , 19 <b>57</b> , to <b>April 8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 8</b> , 19 <b>57</b> , and that death occurred at <b>8:10A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>4/8/57</b>			
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>APR 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	



1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 SALISBURY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>82 PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>201 LINCOLN AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last <b>MILLIGAN</b>		4. DATE OF DEATH Month Day Year <b>APRIL 24 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 24, 1957</b>		9. AGE (In years lost birthday) yrs. Months Days Hours Min. <b>55</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>HARRY HAYDEN MILLIGAN</b>				14. MOTHER'S MAIDEN NAME <b>LOLA JEAN SCHWENING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>HARRY HAYDEN MILLIGAN 201 LINCOLN AVE SALISBURY MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra uterine Anoxia</b> <b>761.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Abruptio Placenta complete.</b> DUE TO (c) <b>1 hr 30 min</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4:24</b> , 19 <b>57</b> , to <b>4:24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7:30 pm 4/24, 1957</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md</b> DATE SIGNED <b>4/25/57</b>							
ACTUAL SIGNATURE <b>Robert Lee Baker</b>				M.D. <b>Salisbury, Md</b>			
PHYSICIAN'S NAME (Type) <b>Robert Lee Baker</b>				<b>Salisbury, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>4-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Peninsula General Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peninsula General Hospital</b>				ADDRESS <b>Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-26-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloman</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

*Handwritten notes and signatures, including "104" and "105" in the center, and "106" on the right.*

BUREAU V. 1

APR 29 1957

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04628

## 4619 CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parsonsborg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D.# 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CLARENCE</u> (Middle) <u>KELSO</u> (Last) <u>MORRIS</u>				(Month) <u>APRIL</u> (Day) <u>7th</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 23, 1902</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>R.D.# 1 Parsonsborg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jason A. Morris</u>				14. MOTHER'S MAIDEN NAME <u>Anna C. Layton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Hilda M. Morris (Wife) R.D.# 1 Parsonsborg, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
340.2 IMMEDIATE CAUSE (A) <u>Bacterial Meningitis</u>						<u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-7</u> , 19 <u>57</u> , to <u>4-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-7</u> , 19 <u>57</u> , and that death occurred at <u>11:30P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wilber Ellis</u>				DATE SIGNED <u>Apr. 9 / 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-</u>		DATE THEREOF <u>Apr. 19, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 12 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</u>			

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STATE OF

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF INTERVIEW

DATE OF SIGNATURE

DATE OF FILING

DATE OF REGISTRATION

DATE OF ENTRY

DATE OF DEATH

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BUREAU V. 1

APR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4620

## CERTIFICATE OF DEATH

Reg. Dist. No.

04627  
337

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke 23422</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>924 Second Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>D.</u> Last <u>Murphy</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ELEW DUCKWORTH</u>				14. MOTHER'S MAIDEN NAME <u>MARY COLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CHARLES S. MURPHY, POCOMOKE, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>4/4</u> , 19 <u>57</u> , to <u>4/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>57</u> , and that death occurred at <u>10:22 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas O. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>224 N. Division St.</u>			
DATE SIGNED <u>  </u>							
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR.</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VERNON MEMORIAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PHILLIPPI, W. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Sallaway</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED MARY ELIZABETH		SEX F		AGE 72	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH 1885		PLACE OF DEATH NEW YORK	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH APRIL 10 1957		TIME OF DEATH 10:30 AM		PLACE OF INTERMENT CATHOLIC CEMETERY	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	

BUREAU V. 3

APR 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04628

4621

CERTIFICATE OF DEATH

Reg. Dist. No. 33✓

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>203 Pierce Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Hester</b> Middle <b>A.</b> Last <b>Neal</b>				4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1875</b>	
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Bivalve, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Levin Horner</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b></b>			
17. INFORMANT <b>Walter Neal, 203 Pierce Ave., Maryland</b>				Address <b>Salisbury,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cardiac insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary disease</b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/7</b> , 19 <b>57</b> , to <b>4-10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/10</b> , 19 <b>57</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. B. Smith</b> M.D.				ADDRESS (Street, city or town, state) <b>Med. Center Shy Md</b>			
DATE SIGNED <b>4/13/57</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bivalve Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bivalve Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. D. Hester</b>				ADDRESS <b>Bivalve, Maryland</b>			
24a. REC'D BY REGISTRAR <b>DR 99 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollaway</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF OTHER	

**RECEIVED**  
**BUREAU V. R.**  
 APR 22 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04629

4622

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>413 Truitt St.,</u>		d. STREET ADDRESS <u>413 Truitt St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>GILLIAM</u> Last <u>NEWTON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1855</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Newton</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Rudd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Harry Welsh, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO <u>Arteriosclerosis of Coronary Arteries</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12, 19 57</u> to <u>April 12, 19 57</u> , that I last saw the deceased alive on <u>April 4th, 19 57</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.		DATE SIGNED <u>4/14/57</u>	
ACTUAL SIGNATURE <u>Mr. Carrie Hearn, M.D.</u>		ADDRESS (Street, city or town, state) <u>226 N. Division St., Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Carrie Hearn, 226 North Division St., Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedarwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Roanoke Rapids, N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 4-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Baker</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15, 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		CITY OF RESIDENCE <i>Baltimore, Md.</i>		COUNTY OF RESIDENCE <i>Baltimore</i>		STATE OF RESIDENCE <i>Md.</i>		CITY OF DEATH <i>Baltimore, Md.</i>		COUNTY OF DEATH <i>Baltimore</i>		STATE OF DEATH <i>Md.</i>			
OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE'S NAME <i>Jane Doe</i>		DATE OF MARRIAGE <i>Jan 1, 1935</i>		PLACE OF MARRIAGE <i>Baltimore, Md.</i>		CITY OF MARRIAGE <i>Baltimore, Md.</i>		COUNTY OF MARRIAGE <i>Baltimore</i>		STATE OF MARRIAGE <i>Md.</i>		CITY OF DEATH <i>Baltimore, Md.</i>		COUNTY OF DEATH <i>Baltimore</i>		STATE OF DEATH <i>Md.</i>			
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>		UNDERLYING CAUSE <i>Arteriosclerosis</i>		DATE OF DEATH <i>Apr 10, 1957</i>		PLACE OF DEATH <i>Home</i>		CITY OF DEATH <i>Baltimore, Md.</i>		COUNTY OF DEATH <i>Baltimore</i>		STATE OF DEATH <i>Md.</i>		CITY OF DEATH <i>Baltimore, Md.</i>		COUNTY OF DEATH <i>Baltimore</i>		STATE OF DEATH <i>Md.</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF FUNERAL HOME <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

APR 8 1957

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4623

CERTIFICATE OF DEATH

Reg. Dist. No.

04630  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Dover Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Nixon</b> Last <b>Nixon</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not known</b>
9. AGE (In years last birthday) <b>about 25</b>		10. IF UNDER 1 YEAR Months <b>25</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>not known</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD, decompensated</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general and cerebral</b> DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Deep sacral decubitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1957</b> to <b>April 27, 1957</b> , that I last saw the deceased alive on <b>April 27, 1957</b> , and that death occurred at <b>1:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Juerman</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>4/27/57</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trappe Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Trappe, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dashiell</b>		24a. REC'D BY REGISTRAR <b>May 6 1957</b>	
ADDRESS <b>Easton, Md</b>		24b. REGISTRAR'S SIGNATURE <b>May 6 1957</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS

DATE OF DEATH

PLACE OF DEATH

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MAY 6 1957

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4624

## CERTIFICATE OF DEATH

Reg. Dist. No.

04631  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar 46X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Rd.,</b>		d. STREET ADDRESS <b>State Hvy.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>MAY</b> Last <b>O'NEIL</b>		4. DATE OF DEATH Month <b>4</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Gordy</b>		14. MOTHER'S MAIDEN NAME <b>Laura Hastings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Doris Savage, Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Congestive Cardiac Failure</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>2 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1957</b> , to <b>April 9, 1957</b> , that I last saw the deceased alive on <b>April 9, 1957</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. H. Lynch</b>		ADDRESS (Street, city or town, state) <b>Delmar, Delmar</b> DATE SIGNED <b>4/10/1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Howard S. Lynch Delaware Ave., Delmar, Delaware</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>		ADDRESS <b>Norman T. Baker</b>	
24a. REC'D BY REGISTRAR <b>4-12-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloman</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HAY		SEX Male		AGE 65		DATE OF BIRTH JAN 15 1892	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH APR 10 1957		PLACE OF DEATH Home		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF REGISTRAR (Signature)	
DATE OF SIGNATURE APR 10 1957		DATE OF SIGNATURE APR 10 1957		DATE OF SIGNATURE APR 10 1957		DATE OF SIGNATURE APR 10 1957	

**RECEIVED**  
APR 15 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG214 5-1-57

4625

## CERTIFICATE OF DEATH

04632

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>All her life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>(Home) 615 Lake Street</b>		d. STREET ADDRESS <b>615 Lake Street</b>	
3. NAME OF DECEASED (Type or print) <b>Bessie Peters</b>		4. DATE OF DEATH 4 21 1957	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-1906</b>
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Grant Peters</b>		14. MOTHER'S MAIDEN NAME <b>Emma Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Lora Dashiell, 615 Lake St, Salisbury, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissiminated carcinomatosis.</b> <b>175x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ovarian carcinoma.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rectal obstruction</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 3, 1954</b> to <b>April 21, 1957</b> , that I last saw the deceased alive on <b>April 21, 1957</b> , and that death occurred at <b>6 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4/23/57</b> DATE SIGNED			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>211 Maryland Avenue, Salisbury, Md.</b>	
PHYSICIAN'S NAME (Type) <b>O. J. Burton, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/25/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Allen, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b>		24a. REC'D BY REGISTRAR DATE <b>4/25/57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Mary Hollanay</b>	



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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04633 33v

Reg. Dist. No. ....

4626

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>605 Railroad Ave.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>(BABY) POWELL</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Apr. 24th 19 57</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Baby</b>	<b>8. DATE OF BIRTH</b> <b>Apr. 23, 1957</b>		<b>9. AGE last birthday</b> <b>(0)</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pen. Gen. Hospital-Salisbury, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Lawrence Edward Powell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Laura Whittington</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Lawrence Edward Powell (Father) 605 Railroad Ave. Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>762.5 IMMEDIATE CAUSE (A)</b> <b>atelectasis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>13 hrs</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Prematurity</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 4/23, 1957, to 4/24, 1957, that I last saw the deceased alive on 4/24, 1957, and that death occurred at 3:00 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>William C. Morgan</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Medical Center - Salisbury, Md.</b>		<b>DATE SIGNED</b> <b>Apr. 25/57</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Apr. 25, 1957</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Riverside Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Worcester Co. Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>APR 29 1957</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2082191/XVI

CERTIFICATE OF DEATH

REG. DIST. NO.

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female) ☐ Male ☐ Female

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Type)

7. CAUSE OF DEATH (Print or Type)

8. MANNER OF DEATH (Print or Type)

9. SIGNATURE OF PHYSICIAN (Print or Type)

10. SIGNATURE OF REGISTRAR (Print or Type)

11. ADDRESS OF DECEASED (Print or Type)

12. ADDRESS OF NEXT OF KIN (Print or Type)

13. ADDRESS OF DECEASED (Print or Type)

14. ADDRESS OF DECEASED (Print or Type)

15. ADDRESS OF DECEASED (Print or Type)

16. ADDRESS OF DECEASED (Print or Type)

17. ADDRESS OF DECEASED (Print or Type)

18. ADDRESS OF DECEASED (Print or Type)

19. ADDRESS OF DECEASED (Print or Type)

20. ADDRESS OF DECEASED (Print or Type)

21. ADDRESS OF DECEASED (Print or Type)

22. ADDRESS OF DECEASED (Print or Type)

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female) ☐ Male ☐ Female

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Type)

7. CAUSE OF DEATH (Print or Type)

8. MANNER OF DEATH (Print or Type)

9. SIGNATURE OF PHYSICIAN (Print or Type)

10. SIGNATURE OF REGISTRAR (Print or Type)

11. ADDRESS OF DECEASED (Print or Type)

12. ADDRESS OF NEXT OF KIN (Print or Type)

13. ADDRESS OF DECEASED (Print or Type)

14. ADDRESS OF DECEASED (Print or Type)

15. ADDRESS OF DECEASED (Print or Type)

16. ADDRESS OF DECEASED (Print or Type)

17. ADDRESS OF DECEASED (Print or Type)

18. ADDRESS OF DECEASED (Print or Type)

19. ADDRESS OF DECEASED (Print or Type)

20. ADDRESS OF DECEASED (Print or Type)

21. ADDRESS OF DECEASED (Print or Type)

22. ADDRESS OF DECEASED (Print or Type)

BUREAU V. 1

APR 29 1957

RECEIVED

National Center - Baltimore

Statewide Cemetery

APR 29 1957

Initial

MCCORMACK & COMPANY - BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4627 CERTIFICATE OF DEATH

Reg. Dist. No. 332

04634

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>md</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>5 Weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>23x02 Snow Hill Rural #1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Wilmer</i> First <i>Powell</i> Middle Last				4. DATE OF DEATH Month <i>4</i> Day <i>23</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27-1885</i>	9. AGE (In years, last birthday) <i>71/6/26</i>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Smart Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert L. Powell</i>				14. MOTHER'S MAIDEN NAME <i>Sallie A. Burnell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, complete service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-30-1002</i>		17. INFORMANT Name <i>Martha Burnell</i> Address <i>Snow Hill, md</i>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>154X</i> DUE TO <i>Carcinoma of Rectum</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Benign</i> (c) <i>Benign prostatic hypertrophy</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Benign prostatic hypertrophy</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4.23.57</i> , 19 <i>57</i> , to <i>4.23.57</i> , that I last saw the deceased alive on <i>4.23.57</i> , 19 <i>57</i> , and that death occurred at <i>3:45 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. A. Briele</i>		M.D. <i>Salisbury, Md.</i>		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>4.23.57</i>	
PHYSICIAN'S NAME (Type) <i>H. A. Briele</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 27/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Wesley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill Rural #1 md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Jones</i>				ADDRESS <i>Snow Hill, md</i>		24a. REC'D BY REGISTRAR DATE <i>4/24/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>May Hallaway</i>			

CERTIFICATE OF DEATH

BUREAU V. 3

APR 26 1957

RECEIVED

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G211 4-29-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

046352

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 HR.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D.O.A. Peninsula Gen. Hospital</u>		d. STREET ADDRESS <u>OCEAN CITY 23X22</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA LUCRETIA Quillen</u>		4. DATE OF DEATH Month Day Year <u>April 14 - 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 21, 1885</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES NOCK</u>		14. MOTHER'S MAIDEN NAME <u>ELLA CROPPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NO</u>	
17. INFORMANT Address <u>MR. VERNON QUILLEN, OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Willen R. Ellis Jr.</u> M.D. _____			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Busby</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04638

## 4629 CERTIFICATE OF DEATH

Reg. Dist. No.

882

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Nursing Home</u>				d. STREET ADDRESS <u>730 Smith St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Allen</u> Last <u>Reaves, Sr.</u>				4. DATE OF DEATH Month <u>4/30</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman General Foods. Corporation</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ky.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Reaves</u>				14. MOTHER'S MAIDEN NAME <u>Francis Wilford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>250-09-9227</u>		17. INFORMANT <u>Mr. James Fields, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>449X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular Accident</u> DUE TO (c) <u>Hypertensive Cardiovascular Dis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 wks</u> <u>yes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/1</u> , 19 <u>56</u> , to <u>4/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>57</u> , and that death occurred at <u>38 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Rufus S. Gardner</u>		ADDRESS (Street, city or town, state) <u>Peninsula Medical, Salisbury, Maryland</u>				DATE SIGNED <u>4/30/57</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sp. Hill Memory Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill &amp; Johnson Co. Salisbury, Maryland</u>				ADDRESS <u>Norman F. Baker</u>		24a. REC'D BY REGISTRAR DATE <u>4-30-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4630

CERTIFICATE OF DEATH

Reg. Dist. No.

04637  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>513 Camden Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CALLIE</b> Middle <b>COOLEY</b> Last <b>RING</b>		4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1868</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS. Days <b>30</b> Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hardin Cooley</b>		14. MOTHER'S MAIDEN NAME <b>Martha Evans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Charles L. Powell</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/24</b> , 19 <b>57</b> , to <b>4/30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/30/57</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Fred R. Gramse</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>	
PHYSICIAN'S NAME (Type) <b>FRED R. GRAMSE</b>		DATE SIGNED <b>S. Division St., Salisbury, Md.</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/3/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Independence Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co.</b>		ADDRESS <b>Salisbury, Md.</b>	
24a. REC'D BY REGISTRAR <b>4-30-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>	

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04638

4631

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>1 Wk.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>Rt #3.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Edwin Robinson</b>		4. DATE OF DEATH Month Day Year <b>4 18 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1870</b>
9. AGE (In years last birthday) yrs. <b>86</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Phila. Transport Co. Motorman</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustus Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Vincent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>179-22-8442</b>	
17. INFORMANT <b>Mrs. Maggie C. Robinson, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary occlusion</b> DUE TO (c) <b>arteriosclerosis generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-11</b> 19 <b>57</b> , to <b>4-18</b> 19 <b>57</b> , that I last saw the deceased alive on <b>4-16</b> 19 <b>57</b> , and that death occurred at <b>930p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delmar, Maryland</b> DATE SIGNED <b>4/22/1957</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Delmar, Maryland</b> PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler 303 East St., Delmar, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/22/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b> <b>Norman S. Baber</b>		24a. REC'D BY REGISTRAR DATE <b>4-22-57</b> 24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloman</b>	

BUREAU V. S.

APR 24 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4632

## CERTIFICATE OF DEATH

Reg. Dist. No.

04639

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>6½ yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>09X02 Fishing Creek</b>			
				d. STREET ADDRESS <b>--</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Milford</b> Middle <b>Tyler</b> Last <b>Ruark</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1903</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>20</b> Days <b>19</b> Hours <b>57</b>		IF UNDER 24 HRS. Months <b>19</b> Days <b>57</b> Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry W. Ruark</b>				14. MOTHER'S MAIDEN NAME <b>Clara L. Tyler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>422.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury</b>				20g. (County) <b>Salisbury</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct. 17, 1950</b> , to <b>April 20, 1957</b> , that I last saw the deceased alive on <b>April 20, 1957</b> , and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>				DATE SIGNED <b>4/20/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hoosier Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Fishing Creek Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 4/23/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Halloway</b>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		APR 4, 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. E.

APR 30 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4633

CERTIFICATE OF DEATH

Reg. Dist. No.

04640  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>23422</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>905 Walnut Street</b>			
3. NAME OF DECEASED First <b>Ruth</b> Middle <b>Estelle</b> Last <b>Ryall</b>				4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1893</b>		9. AGE (In years lost birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia, USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Festus Watson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Estelle Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Deer's Head Hospital Records, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic lymphatic leukemia</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>--</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19 57</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		
					(State)		
21. I certify that I attended the deceased from <b>January 9, 19 57</b> , to <b>April 18, 19 57</b> , that I last saw the deceased alive on <b>April 18, 19 57</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>		DATE SIGNED <b>4/19/57</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. U. Johnson</b>				ADDRESS <b>Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>4-19-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>			



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4634

## CERTIFICATE OF DEATH

Reg. Dist. No.

046432

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>603 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>			d. STREET ADDRESS <b>Morganza 18x02</b>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Victoria</b> Last <b>Sinnickson</b>			4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 57</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/1875</b>		9. AGE (In years lost birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>?</b>		
14. MOTHER'S MAIDEN NAME <b>?</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		
16. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT <b>Mr. Louis Francis Sinnickson (Husband)</b> <b>Hospital Records, 624 S. Division St. Salisbury, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>?</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> p. m. Month, Day, Year <b>19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>Aug. 17, 1955</b> , to <b>April 11, 1957</b> , that I last saw the deceased alive on <b>April 11, 1957</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>L. V. Maldve</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>			
DATE SIGNED <b>4/11/57</b>		M.D. <b>Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 15, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 15 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4635  
CERTIFICATE OF DEATH

Reg. Dist. No.

04642  
332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>22 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY 23422</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>612 LAUREL STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ACARITAN</u> First <u>B. Skidmore</u> Middle Last				4. DATE OF DEATH <u>April 30</u> 19 <u>57</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 24, 1880</u> 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
13. FATHER'S NAME <u>ISSAC SKIDMORE</u>				14. MOTHER'S MAIDEN NAME <u>ANNA AMELIA BALDWIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-12-2303A</u>		17. INFORMANT <u>MRS WILLIAM B. SCHOLFIELD, Pocomoke MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-8</u> , 19 <u>57</u> , to <u>4-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>57</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Walter R. Ellis, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CAPEVILLE MASONIC CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CAPEVILLE, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>POCOMOKE, MD.</u>				24a. REC'D BY REGISTRAR <u>May 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Holloway</u>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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MAY 3 1957

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may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04643

4636

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 yrs. 9 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. STREET ADDRESS <u>615 N. Bentalou Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Virginia</u> Last <u>Smullen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elihu Hitchens</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Jane Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>213-12-8511D</u>		17. INFORMANT <u>Deer's Head State Hospital, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis, Multiple</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>  <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 17, 19 51</u> to <u>April 29, 19 57</u> , that I last saw the deceased alive on <u>April 29, 19 57</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>4/29/57</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u> <u>Yonny B. Baker</u>				24c. REC'D BY REGISTRAR DATE <u>4-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>	

# CERTIFICATE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

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Dr. Lawry

4637

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>828 S. Division St</b>				STREET ADDRESS <b>828 S. Division St</b>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>NIMLS</b> (Middle) <b>SORENSEN</b> (Last)				(Month) <b>April</b> (Day) <b>18th</b> 19 <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>August 4, 1899</b>	9. AGE last birthday <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman (Worked on Boats)</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Aashus Denmark</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Sorensen</b>				14. MOTHER'S MAIDEN NAME <b>Kirsten Jeaperson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Irene C. Sorensen (Wife) 828 S. Division St. Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
581.0 IMMEDIATE CAUSE (A) <b>Cirrhosis of Liver</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 4-18-57</b> , 19 <b>49</b> , to <b>4-18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-18-57</b> , 19 <b>57</b> , and that death occurred at <b>11:50A</b> , from the causes and on the date stated above.							
SIGNATURE <b>Dr. Lee Lawry</b>				ADDRESS (Street, city, town, state) <b>Fruitland, Maryland</b>		DATE SIGNED <b>Apr. 19 1957</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Apr. 19, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Spring Hill Mem. Gardens R.D. # Hebron, Maryland</b>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <b>APR 22 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

APR 22 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>Minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>East Street</b>				d. STREET ADDRESS <b>none</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>---</b> Last <b>SPRIGGS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1885</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>57</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Tylerton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Ann Bradshaw</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Harvey Spriggs</b>		Address <b>Ewell, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior-sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Anterior Sclerosis</b> DUE TO (c) <b>Generalized Anterior Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Yes.</b> <b>Yes.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 5, 19 57</b> to <b>April 30, 19 57</b> that I last saw the deceased alive on <b>April 30, 19 57</b> , and that death occurred at <b>3:05 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald F. Bartley</b> M.D.				ADDRESS (Street, city or town, state) <b>9 N. HANSON ST. EASTON, MD.</b>			
PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY M.D.</b>				DATE SIGNED <b>5-2-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ewell Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ewell, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw, Crisfield, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 5-27-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. H. H.</b>	

CERTIFICATE OF DEATH

4026

NAME OF DECEASED HARRISON DUNN		SEX MALE		AGE 30		DATE OF BIRTH APR 11 1925		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH MAY 1 1957		PLACE OF DEATH BALTIMORE, MARYLAND	
EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARITAL STATUS MARRIED		DATE OF MARRIAGE JULY 15 1945		NAME OF SPOUSE JANE DUNN	
PREVIOUS ILLNESS NONE		HISTORY OF PRESENT ILLNESS HEART DISEASE		HISTORY OF PRESENT ILLNESS HEART DISEASE		HISTORY OF PRESENT ILLNESS HEART DISEASE		HISTORY OF PRESENT ILLNESS HEART DISEASE	
SIGNATURE OF PHYSICIAN J. H. DUNN		SIGNATURE OF PHYSICIAN J. H. DUNN		SIGNATURE OF PHYSICIAN J. H. DUNN		SIGNATURE OF PHYSICIAN J. H. DUNN		SIGNATURE OF PHYSICIAN J. H. DUNN	

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MAY 29 1957  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4638

## CERTIFICATE OF DEATH

04645

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>10 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>--</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>--</u> Last <u>Stevens</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1867</u>		9. AGE (In years last birthday) <u>90</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nelson Foster</u>				14. MOTHER'S MAIDEN NAME <u>Alice Wheat</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Deer's Head Hospital Records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>--</u> DUE TO (c) <u>--</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pernicious anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 13, 19 56</u> , to <u>April 19, 19 57</u> , that I last saw the deceased alive on <u>April 19, 19 57</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>				DATE SIGNED <u>4/19/57</u>			
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Hall</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill Md.</u>				24a. REC'D BY REGISTRAR <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	
<p>13. Name of informant: _____</p>		<p>14. Address of informant: _____</p>	
<p>15. Name of informant: _____</p>		<p>16. Address of informant: _____</p>	
<p>17. Name of informant: _____</p>		<p>18. Address of informant: _____</p>	
<p>19. Name of informant: _____</p>		<p>20. Address of informant: _____</p>	
<p>21. Name of informant: _____</p>		<p>22. Address of informant: _____</p>	
<p>23. Name of informant: _____</p>		<p>24. Address of informant: _____</p>	
<p>25. Name of informant: _____</p>		<p>26. Address of informant: _____</p>	
<p>27. Name of informant: _____</p>		<p>28. Address of informant: _____</p>	
<p>29. Name of informant: _____</p>		<p>30. Address of informant: _____</p>	
<p>31. Name of informant: _____</p>		<p>32. Address of informant: _____</p>	
<p>33. Name of informant: _____</p>		<p>34. Address of informant: _____</p>	
<p>35. Name of informant: _____</p>		<p>36. Address of informant: _____</p>	
<p>37. Name of informant: _____</p>		<p>38. Address of informant: _____</p>	
<p>39. Name of informant: _____</p>		<p>40. Address of informant: _____</p>	
<p>41. Name of informant: _____</p>		<p>42. Address of informant: _____</p>	
<p>43. Name of informant: _____</p>		<p>44. Address of informant: _____</p>	
<p>45. Name of informant: _____</p>		<p>46. Address of informant: _____</p>	
<p>47. Name of informant: _____</p>		<p>48. Address of informant: _____</p>	
<p>49. Name of informant: _____</p>		<p>50. Address of informant: _____</p>	
<p>51. Name of informant: _____</p>		<p>52. Address of informant: _____</p>	
<p>53. Name of informant: _____</p>		<p>54. Address of informant: _____</p>	
<p>55. Name of informant: _____</p>		<p>56. Address of informant: _____</p>	
<p>57. Name of informant: _____</p>		<p>58. Address of informant: _____</p>	
<p>59. Name of informant: _____</p>		<p>60. Address of informant: _____</p>	
<p>61. Name of informant: _____</p>		<p>62. Address of informant: _____</p>	
<p>63. Name of informant: _____</p>		<p>64. Address of informant: _____</p>	
<p>65. Name of informant: _____</p>		<p>66. Address of informant: _____</p>	
<p>67. Name of informant: _____</p>		<p>68. Address of informant: _____</p>	
<p>69. Name of informant: _____</p>		<p>70. Address of informant: _____</p>	
<p>71. Name of informant: _____</p>		<p>72. Address of informant: _____</p>	
<p>73. Name of informant: _____</p>		<p>74. Address of informant: _____</p>	
<p>75. Name of informant: _____</p>		<p>76. Address of informant: _____</p>	
<p>77. Name of informant: _____</p>		<p>78. Address of informant: _____</p>	
<p>79. Name of informant: _____</p>		<p>80. Address of informant: _____</p>	
<p>81. Name of informant: _____</p>		<p>82. Address of informant: _____</p>	
<p>83. Name of informant: _____</p>		<p>84. Address of informant: _____</p>	
<p>85. Name of informant: _____</p>		<p>86. Address of informant: _____</p>	
<p>87. Name of informant: _____</p>		<p>88. Address of informant: _____</p>	
<p>89. Name of informant: _____</p>		<p>90. Address of informant: _____</p>	
<p>91. Name of informant: _____</p>		<p>92. Address of informant: _____</p>	
<p>93. Name of informant: _____</p>		<p>94. Address of informant: _____</p>	
<p>95. Name of informant: _____</p>		<p>96. Address of informant: _____</p>	
<p>97. Name of informant: _____</p>		<p>98. Address of informant: _____</p>	
<p>99. Name of informant: _____</p>		<p>100. Address of informant: _____</p>	

BUREAU V. E.

APR 25 1957

RECEIVED

4639

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u>			c. LENGTH OF STAY IN 1b <u>237 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u>			d. STREET ADDRESS <u>Mulberry Street</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Russell</u> Last <u>Stevens</u>			4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u> <u>1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
13. FATHER'S NAME <u>George Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of stomach with metastases</u> <u>151x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>026x CNS lues - treated</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 7, 1956</u> , to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>10:45A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>Dr. Juerman</u>		M.D. <u>Deer's Head State Hospital</u> <u>4/1/57</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman</u>		M.D. <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Bldg.</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks M. West</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>APR 8 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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BUREAU V. S.

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4640

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

04647

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARION 19x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Swift</u> Last <u>Swift</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1893</u>	
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Roger Swift, Marion, Md</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Myocardial Thromboses</u> 560.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive P. O. Ventral Rupture</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>4:23</u> , 19 <u>57</u> , to <u>4:26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4:26</u> , 19 <u>57</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Briele</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>				DATE SIGNED <u>4-26-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rehobeth Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Rehobeth, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw &amp; Sons, Crisfield, Md.</u>				ADDRESS <u>7 Bradshaw &amp; Sons, Crisfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-28-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James William Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>April 15, 1957</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
DATE OF BIRTH <i>March 10, 1912</i>		PLACE OF BIRTH <i>Harford, Md.</i>		FATHER'S NAME <i>John Smith</i>		MOTHER'S NAME <i>Mary Smith</i>	
MARITAL STATUS <i>Married</i>		SPOUSE'S NAME <i>Elizabeth Smith</i>		SPOUSE'S ADDRESS <i>123 Main St, Baltimore, Md.</i>		SPOUSE'S OCCUPATION <i>Homemaker</i>	
PREVIOUS ILLNESS <i>None</i>		PREVIOUS SURGERY <i>None</i>		PREVIOUS TRAUMA <i>None</i>		PREVIOUS DRUGS <i>None</i>	
PHYSICIAN'S SIGNATURE <i>[Signature]</i>		DATE <i>April 15, 1957</i>		HOSPITAL <i>None</i>		NURSE'S SIGNATURE <i>[Signature]</i>	
DEATH CERTIFICATE NO. <i>12345</i>		REGISTRATION NO. <i>67890</i>		FILING NO. <i>11122</i>		INDEXING NO. <i>33344</i>	

**RECEIVED**  
MAY 1 1957  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4641

## CERTIFICATE OF DEATH

Reg. Dist. No.

04648  
332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 yr 4½ mo.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels 20 x 92</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>--</b>				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Anna</b> Last <b>Todd</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>57</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1874</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore Noske</b>				14. MOTHER'S MAIDEN NAME <b>Mansfield (Munsfeldt)</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Deer's Head State Hospital, Salisbury, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ca of right breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old C.V.A.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 7, 1953</b> , to <b>April 25, 1957</b> , that I last saw the deceased alive on <b>April 25, 1957</b> , and that death occurred at <b>1:10 P.M.</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>L. V. Maldve</b>				M.D. <b>Deer's Head State Hospital</b>				DATE SIGNED <b>4/25/57</b>			
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>April 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ST. MICHAELS MARYLAND</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman D. Marshall</b>						ADDRESS <b>ST. MICHAELS, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 30 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary St. Holloway</b>	

BUREAU V. S.

APR 30 1957

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4642 **CERTIFICATE OF DEATH**04649 337  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>3 - Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke (Rural)</u>		<u>23x02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. # 3</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Jane Wiltha Townsend</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 2nd 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 31, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Worcester Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Pruitt</u>				14. MOTHER'S MAIDEN NAME <u>Julia Houten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mrs. Evelyn Hastings (Daughter) Pineway Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive Cardio-Vascular Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/30</u> , 19 <u>57</u> , to <u>4/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>57</u> , and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Thomas C. Hill</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>M.D. 224 N. Division St. Salisbury, Maryland 4/2/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 4, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>APR 4 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</u>			

# CERTIFICATE OF DEATH

Form No. 1

DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

1957

MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE, MD.

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BUREAU V. S.

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04650

4643

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Md.</b>		c. LENGTH OF STAY IN 1b <b>421 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Snow Hill 23x02</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>			d. STREET ADDRESS <b>Timmons Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Tona Charlotte Truitt</b>			4. DATE OF DEATH Month Day Year <b>April 16 19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1870</b>		9. AGE (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pocomoke City, Md.</b>	
13. FATHER'S NAME <b>George W. Hancock</b>			14. MOTHER'S MAIDEN NAME <b>Annie Bonnvillie</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>Feb. 20, 19 56</b> to <b>April 16, 19 57</b> , that I last saw the deceased alive on <b>April 16, 19 57</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Dr. b. Juerman</b>			M.D. <b>Deer's Head State Hospital 4/16/57</b>		
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>			<b>Salisbury, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial April 19 57</b>		22b. DATE THEREOF <b>April 19 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old School Baptist Church</b>	
22d. LOCATION (City, town, or county) <b>Snow Hill</b>		(State) <b>md</b>		24a. REC'D BY REGISTRAR <b>APR 22 1957</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne Timmons</b>		ADDRESS <b>Snow Hill, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Mary J. Holloway</b>	

CERTIFICATE OF DEATH

Date of Death APR 22 1957		Place of Death HOME	
Name of Deceased JAMES H. WHITE		Sex Male	
Date of Birth APR 11 1901		Age 56	
Usual Residence 1234 E. BALTIMORE ST. BALTIMORE, MD.		Cause of Death HEART DISEASE	
Physician DR. J. H. SMITH		Burial Place GREENWOOD CEMETERY	
Signature of Physician J. H. SMITH		Signature of Registrar J. H. SMITH	

BUREAU V. R.

APR 22 1957

RECEIVED

1

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04651

## 4657 CERTIFICATE OF DEATH

Item 9 FilmG213 4-11-57 et

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Willards (Rural)</b>		LENGTH OF STAY (in this place) <b>1</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Willards (Rural)</b>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D.# 1</b>				STREET ADDRESS <b>R.D.# 1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>ELMER</b> (First) <b>LEE</b> (Middle) <b>TYNDALL</b> (Last)				<b>4. DATE OF DEATH</b> (Month) <b>April</b> (Day) <b>2nd</b> (Year) <b>19 57</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Nov. 8th, 1885</b>	<b>9. AGE last birthday</b> <b>79 71 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>24</b>	<b>IF UNDER 24 HRS.</b> Hours <b>4</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wicomico Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Robert Samuel Tyndall</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Driscoll</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Mamie A. Tyndall (Wife) R.D.# 1 Willards, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X</b> IMMEDIATE CAUSE (A) <b>cerebral hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>degenerative heart disease.</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from Dec 34, 1954, to 4/2, 1957, that I last saw the deceased alive on 4/1, 1957, and that death occurred at 10:05 PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Dr. Earl Beardsley</b>		<b>DATE SIGNED</b> <b>APR 4 1957</b>					
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial-</b>		<b>DATE THEREOF</b> <b>Apr. 4th, 1957</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Line Church Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Near Pittsville, Maryland</b>	
<b>24. RECEIVED BY REGISTRAR</b> <b>APR 8 1957</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>		<b>ADDRESS</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04652  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wicomico River</b>				d. STREET ADDRESS <b>713 Howard St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>LORENZO</b> Last <b>WALKER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1931</b>		9. AGE (In years last birthday) <b>26</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Ernest C. Walker</b>				14. MOTHER'S MAIDEN NAME <b>Marie M. Haughey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Korea War</b>		16. SOCIAL SECURITY NO. <b>220-26-8185</b>		17. INFORMANT <b>Mrs. Marie M. Walker (Mother)</b> Address <b>713 Howard St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1st 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>MAY 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of Birth: [illegible]  
5. Date of Death: [illegible]  
6. Place of Death: [illegible]  
7. Cause of Death: [illegible]  
8. Manner of Death: [illegible]  
9. Signature of Medical Examiner: [illegible]  
10. Signature of Coroner: [illegible]  
11. Signature of Registrar: [illegible]

BUREAU V. B.

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

046533v

4645

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY 12</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>316 MARTIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First Middle Last <u>WARD</u>				4. DATE OF DEATH <u>April 18</u> 19 <u>57</u> Month Day Year					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-6-1868</u> 89 yrs.			
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles Sturgis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Parsons</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Bertha Adkins, Salisbury, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>4-16</u> , 19 <u>57</u> , to <u>4-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>57</u> , and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>David J. Selmon</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>April 19, 1957</u>					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>4-20-1957</u>		<u>Mt Olive</u>		<u>Delmar Del</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar Del</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>					

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint, illegible text]</p>		<p>2. SEX                  [Faint, illegible text]</p>	
<p>3. AGE                  [Faint, illegible text]</p>		<p>4. DATE OF BIRTH                  [Faint, illegible text]</p>	
<p>5. PLACE OF BIRTH                  [Faint, illegible text]</p>		<p>6. OCCUPATION                  [Faint, illegible text]</p>	
<p>7. MARITAL STATUS                  [Faint, illegible text]</p>		<p>8. CAUSE OF DEATH                  [Faint, illegible text]</p>	
<p>9. MEDICAL HISTORY                  [Faint, illegible text]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [Faint, illegible text]</p>	
<p>11. SIGNATURE OF REGISTRAR                  [Faint, illegible text]</p>		<p>12. DATE OF DEATH                  [Faint, illegible text]</p>	

BUREAU V. S.

APR 23 1957

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

4646

04654

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Pennsylvania</b>		COUNTY <b>Lackawanna</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Moscow (Rural) 75x.3</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Riverside Drive</b>				STREET ADDRESS <b>R.D.# 2</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>THOMAS</b> (Middle) <b>ARTEUR</b> (Last) <b>WARD</b>				(Month) <b>April</b> (Day) <b>19th</b> (Year) <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 6th, 1894</b>	9. AGE last birthday <b>62</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Metal Worker (Auto Body Repair)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Moscow, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Francis Edward Ward</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <b>Mrs. Margaret Ward (Wife) R.D.# 2 Moscow, Pennsylvania</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE (A) <b>Pulmonary embolism</b>						<b>1 1/2 h</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arterio Sclerosis</b>						<b>2 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Carcinoma of Lung</b>						<b>1 yr</b>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 4/19</b> , 19 <b>57</b> , to <b>April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/19</b> , 19 <b>57</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Dr. Alberta Mattax</b>				ADDRESS (Street, city, town, state) <b>711 Camden Ave. Salisbury, Maryland</b>			
DATE SIGNED <b>4/19/57</b>				DATE SIGNED <b>4/19/57</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Apr. 23, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Spring Brook Cemetery</b>		LOCATION (City, town, or county) (State) <b>R.D.# Moscow, Pennsylvania</b>	
24. REC'D BY REGISTRAR <b>APR 22 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

File No. 12

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 12th day of April, 1957.

Signature of Registrar  
Name (Print)  
Address

Signature of Physician  
Name (Print)  
Address

Signature of Coroner  
Name (Print)  
Address

Signature of Medical Examiner  
Name (Print)  
Address

Signature of Health Officer  
Name (Print)  
Address

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	Cause of Death	Signature of Registrar	Signature of Physician	Signature of Coroner	Signature of Medical Examiner	Signature of Health Officer
WILSON, James	45	M	W	1912	1957	London, England	London, England	Heart Disease					
THOMAS, John	35	M	W	1922	1957	London, England	London, England	Heart Disease					
WILSON, James	45	M	W	1912	1957	London, England	London, England	Heart Disease					
THOMAS, John	35	M	W	1922	1957	London, England	London, England	Heart Disease					

Signature of Registrar

Name (Print)  
Address

Signature of Physician

Name (Print)  
Address

BUREAU V. S.

APR 26 1957

RECEIVED

711 Oregon Ave.  
Baltimore, Maryland  
HOLLAND & COMPANY - BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4647

## CERTIFICATE OF DEATH

Reg. Dist. No.

04655

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>22 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LINDEN</u> Middle <u>WILKERSON</u> Last <u>WILKERSON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1902</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. AGE (In years last birthday) <u>54</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Non-owner</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
13. FATHER'S NAME <u>CHARLES Wilkerson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Delema SMITH</u>		15. SOCIAL SECURITY NO. <u>215-14-3402</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT <u>Mrs. Gladys Wilkerson</u> Address <u>Willards, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Insufficiency; Thrombophlebitis</u> (c) <u>163X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 9, 1957</u> to <u>APR 1, 1957</u> , that I last saw the deceased alive on <u>1957</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		DATE SIGNED <u>April 1, 1957</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Farlow's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Willis Wells</u>		24a. REC'D BY REGISTRAR <u>APR 4 1957</u>	
ADDRESS <u>Chestertown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

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